MASTER OF PUBLIC POLICY
CAPSTONE PROJECT

Aging in Place and Aging in Grace: What Seniors In Alberta Really Want

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Capstone Approval Page

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Contents

Abstract

Home care for seniors in Alberta has been receiving growing public attention. There are many publicly funded long-term care facilities where clients can reside full-time and receive services as residents, but 77% of Canadians want to "age in place". Alberta budgeted $755.1 million for home care services in 2022, and increased the budget to $902.8 million in 2023. It is unclear exactly how this money is being spent, and even more unclear how this money may or may not be meeting the needs of disabled seniors in Alberta. The theoretical framework used as an underpinning for this analysis is critical gerontology as defined by Chong and Gu (2020). Critical gerontology is a way of understanding aging that recognizes aging as not only a physiological process but a socially defined and dynamic phenomenon. Based on the literature and the current policy landscape in Alberta, the report assesses 3 policy options to improve access to quality home care for disabled seniors: maintaining the status quo, increasing regulatory oversight of home care, and reducing the barriers to self-managed care. The analysis recommends that the Government of Alberta pursue reducing barriers to self-managed care for disabled seniors. Increasing access to guided, self-managed home care for seniors in Alberta would be the most effective use of home care budgetary provisions and would be the most feasible compromise between institutional desires and individual needs.

Keywords: home care, seniors, health policy, disability, critical gerontology

Executive Summary

Problem: Seniors in Alberta continue to express their growing desire to "age in place" instead of living in residential care facilities. The current aged care systems in place in Alberta do not have the capacity to support Albertan seniors in their own homes.

Importance: 77% of Canadians want to age in place as opposed to living in residential care facilities, which are either cost-prohibitive or poor quality. Additionally, by 2036 it is expected that seniors – people aged 65 and older – will make up 25% of Alberta's population. Because of a lack of residential care spaces, an estimated 7,500 seniors stay in hospitals long-term which costs $11.3 million per day nationally. Home care is becoming not only a hot topic but a crisis for some of Alberta's most vulnerable people.

Recommended Action: It is recommended that the Government of Alberta reduce barriers to self-managing care for seniors who wish to age in place. Currently for an individual to manage their own care, they must register themselves as a small business and comply with all related operational laws. By decreasing barriers to self-managed care, home care funding will be administered more effectively which allows for more efficient reallocation of funds.

Key Points: Four main themes emerged from the literature: best practice in home care, community inclusion of disabled seniors, aging is a dynamic and socially defined process, and the quality of care or care outcomes. These themes are each critical to understanding home care policy in Alberta, and critical to moving forward as Alberta attempts to support its aging population.

Introduction

Home care for seniors in Alberta has been receiving growing public attention. Home care is defined as medical services administered in the client's residence, and in this paper "senior" is defined as being 65 years of age and older so as to align with current government program guidelines for seniors' services. It is estimated that by 2036 roughly 25% of Canada's population will be over the age of 65 (Torjman 2013). Home care services are in short supply and will continue to grow more and more scarce as the population age trends older (Torjman 2013). There are many publicly funded long-term care facilities where clients can reside full-time and receive services as residents, but 77% of Canadians want to "age in place" – remain in their own homes and out of public residential institutions (Torjman 2013). In addition to the overwhelming desire to age in place, there is often a critical shortage of space in publicly funded long-term care institutions. In 2011, 99% of Ontario's long-term care spaces were filled, which left 19,000 seniors waiting for a space to open up (Torjman 2013). A lack of residential care capacity impacts more than just the individuals who are waiting for placement. It is estimated that 7,500 Canadian seniors live in hospitals because they have nowhere else to go where they can receive their necessary medical care, which adds up to roughly $11.3 million per day nation-wide – $14.8 million per day when indexed to 2023 (Torjman 2013).

It is also difficult to assure the quality of care provided in residential facilities. If there is a high demand for care services and a critical shortage of available alternative options for care – as is currently the case – vulnerable seniors are often trapped in situations where the care they receive is lacking at best, and dangerous at worst (Eika 2009). This is a critical gap in Alberta's social safety net, ad seniors who do not receive quality residential care if any residential care rely increasingly on informal, unpaid support provided by family members and friends (Ceci and Purkis 2011). Many seniors are wary of "burdening" their loved ones with their health needs even when formal, paid home care services are provided (Barken 2017). Some seniors are so hesitant to place responsibility for their care on their loved ones that, under conditions of economic rationing and social safety net budget cuts, they would rather allow their health to deteriorate rapidly and "suffer in silence" (Livadiotakis, Gutman, and Hollander 2003).

Policy Problem

The existing in-home care service network is not sufficient to meet the needs of seniors in Alberta, particularly given the aging demographic trend in Alberta and the growing desire of seniors to remain in their own homes as they age.

Background

Current Policy in Alberta

In Canada, the provinces are responsible for delivering health care services and social supports, which includes home care (Torjman 2013). Alberta budgeted $755.1 million for home care services in 2022, and increased the budget to $902.8 million in 2023. The purpose of this money is to increase health care staff wages, return to pre-pandemic levels of activity, and invest in increased home care system capacity (Alberta Health Services 2023). This is a $147.7 million increase (Alberta Health Services 2023). It is unclear exactly how this money is being spent, and even more unclear how this money may or may not be meeting the needs of disabled seniors in Alberta. Home care services are explicitly established as a public health entitlement in the *Public Health Act, RSA 2000, c P-37*, and are selectively covered by public health insurance in Alberta according to the *Co-ordinated Home Care Program Regulation, Alta Reg 296/2003*.

The legal framework surrounding home care is vague outside of the recognition that Albertans are allegedly entitled to publicly-funded formal home care under certain eligibility criteria. The *Co-ordinated Home Care Program Regulation* does not specify which health professionals are legally able to provide care. Additionally, the *Health Professions Act, SA 1999, c H-5.5* does not specify which of the regulated health professions are able to perform care within a client's home. The lack of a centralized regulatory body for home care providers is alarming to many (Torjman 2013). Because of a lack of regulation and increasing uncertainty about the exact services provided by formal home care, many seniors in Alberta are relying on their friends and family members to provide necessary medical care (Cranford 2020). Indeed the majority of home care provided is for seniors who are socially isolated, and have several activities of daily living (e.g., bathing, using the toilet, cooking) that they require assistance to perform (Kadushin 2004).

Methods

Theoretical Framework

The theoretical framework used as an underpinning for this analysis is critical gerontology as defined by Chong and Gu (2020). Critical gerontology is a way of understanding aging that implicitly considers intersectional factors of individuals' experiences based on their various identities, and recognizes that aging is not only a physiological process but a socially defined and dynamic phenomenon. Critical gerontology also aligns with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), to which Canada is a ratifying member. The UNCRPD therefore has a great deal of influence on disability policy in Alberta, and will be used as a secondary guiding theoretical framework in this analysis.

Search Strategy

Multiple searches were conducted using different combinations of key words to ensure that the data being collected was representative of the complexity inherent to home care policy. Future searches could then be refined and adjusted so that the data being gathered represented the nuances of the topic. Searches were labelled alphabetically

in order to keep track of which terms were used in which order, beginning with A and ending with G. The table below outlines the search terms used first in the University of Calgary Library database then in the OVID Embase and APA PsycArticles databases.

A	“care recipient” and “disabled” and “elderly” and “home care”
B	“recipient” and “home care” and “funding” and “elderly”
C	“consumer-directed care” and “disability” and “elderly”
D	“care user” and “experience” and “disability” and “home”
E	“best practice” and “home care” and “elderly”
F	“home care” and policy” and “Canada” and “elderly”
G	“Alberta” and “funding” and “home care” and “policy”

Table 1 – Search terms used in literature review.

An extensive investigation was also conducted into Alberta’s regulations and policies regarding home care. The same key terms were used to search the Canadian Legal Information Institute (CanLII) for Alberta regulations about home care and the provision of public health services in Alberta. Public Government of Alberta websites contain policies about home care eligibility and the details of what exact care is provided for disabled seniors, and those were also extensively searched. To capture any outstanding information on home care and the details of how home care is funded beyond the information publicly available in the provincial fiscal plans, a Freedom of Information and Privacy request was submitted and fulfilled by the Ministry of Health.

Data Extraction

Prior to conducting searches, inclusion and exclusion criteria were determined ahead of the initial screening to ensure that the review process would be replicable and reliable. The inclusion criteria used was: English language, published from 2000 to the present, focuses on seniors or adults and not children, centres the lived experiences of disabled people as opposed to their care providers, and gives an economic and/or policy overview of home care provision in Canadian and non-Canadian jurisdictions. An analytical framework from the National Collaborating Centre for Healthy Public Policy (NCCHPP) was used as the basis for the search methodology in this policy analysis. The NCCHPP recommends a modified Cochrane-style review for public policy work, where databases are first searched using key words, then screened based on abstract and title relevancy to the identified topic, screened by a full-text review for relevancy, and included in the review if the source remains relevant. A PRISMA flow chart is included below as a visual aid to understand the screening and extraction process.

Once the searches were completed for academic, grey, and legal literature, the sources were organized into themes based on key points from critical gerontological theory and the UNCRPD. The four key themes identified are: best practice, recipient outcomes and quality of care, community inclusion and aging in place, and aging as a dynamic and social process.

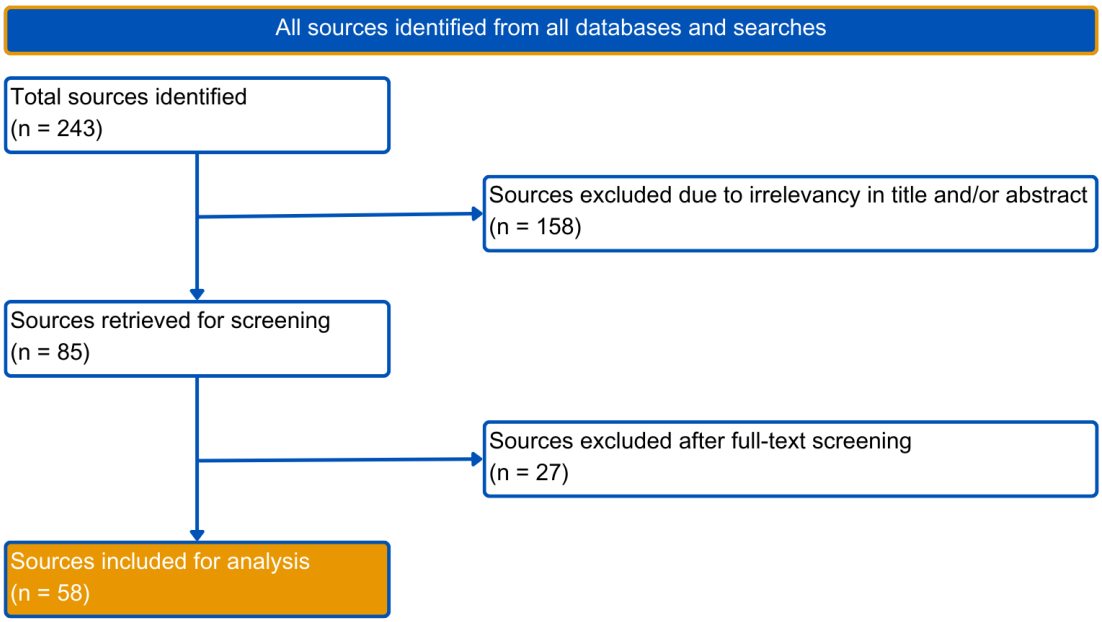

Figure 1 – PRISMA chart of data extraction process, created by the author.

Policy Analysis Criteria

Potential options to address the gaps in Alberta's home care system are based on the analytic process designed by the National Collaborating Centre for Healthy Public Policy (NCCHPP). Six domains for analysis will be considered: effectiveness, unintended effects, equity, cost, feasibility, and acceptability (Morestin et al. 2010). A table organizing these domains into categories based into the impacts of the policy and the implementation of it is below, along with a brief definition of each domain.

Effects	Effectiveness	Which effects does this policy have on the problem?
	Unintended Effects	What are some possible unintended impacts of the policy?
	Equity	Does this policy impact different social groups in different ways?
Implementation	Cost	How much will this policy cost?
	Feasibility	Is the policy actually feasible/realistic to implement?
	Acceptability	Will the relevant stakeholders accept this policy?

Table 2 – Adapted from Morestin et al. (2010).

Based on these criteria, a rubric was developed as an objective analytic framework to evaluate the policy alternatives.

CRITERIA	1 – WEAK	2 – MODERATE	3 – STRONG
EFFECTIVENESS	Will not address the lack of adequate home care for disabled seniors in Alberta.	More seniors will receive in-home care services, but there will still be seniors with unaddressed care needs.	The majority of seniors in Alberta will have the ability to receive in-home care services.
UNINTENDED EFFECTS	Many downstream effects from the policy, such as increased strain on the health system and	There will be some downstream effects that were not intended, but the	There will be few unintended effects of the policy, and the effects that occur will be

	increased costs of hospital-based care system-wide.	costs will be tolerable compared to the benefits of the policy.	negligible in comparison to the positive intended effects of the policy.
EQUITY	Seniors will face further physical and emotional strain due to the policy.	Some seniors may experience better care outcomes while others may experience worse outcomes.	The majority of seniors will benefit from this policy with few disproportionate impacts on seniors who do not benefit.
COST	The policy will be more expensive both short- and long-term. Outcomes will not be worth the financial investment.	The policy may come with up-front costs but will result in the potential for systemic budget reallocation in the future. Moderate costs compared to the present.	The policy will cost a comparable amount to what is spent in similar areas at present. Outcomes will justify the investment.
FEASIBILITY	The policy will be challenging to implement and any impacts will not be apparent for a long time.	The policy may require some structural reorganization, but will ultimately be doable.	The policy will be easy to implement compared to other options, and can either be implemented based on current systems or with some support from other systems.
ACCEPTABILITY	The government and key stakeholders in the public will either not be interested in implementing this policy, or will have substantial opposition to this policy.	There will be some opposition to the policy, but the problem is either on the political agenda or there is a good opportunity to implement the policy.	The majority of key stakeholders in both the government and the public will be in favour of implementing this policy.

Table 3 – Decision criteria evaluative rubric made by the author.

Results

Literature Review

The literature review for this capstone was conducted using the above methodology and organized into sections based on the four common reoccurring themes found throughout the literature. There is significant overlap in the four key themes, and all are critical to understanding the academic context of in-home care for disabled seniors. The first set of searches with the University of Calgary Library yielded 197 sources that were then screened by title and abstract content. After the first screening, only 58 were examined in full for relevancy. 46 sources were selected for analysis. For the second set of searches done in the 2 OVID databases identified above, results were filtered to only include full text articles with abstracts, published in the English language, and from 2000 to present. 38 sources were identified, and after the first stage of screening only 19 were retrieved for a full-text screen. Only 4 sources were included in for analysis after a full screening. The same key terms were used to search the Canadian Legal Information Institute (CanLII) for Alberta regulations about home care and the provision of public health services in Alberta. Public Government of Alberta websites contain policies about home care eligibility and the details of what exact care is provided for disabled seniors, and those were also extensively investigated. To unearth any outstanding information on home care and the details of how home care is funded beyond the information publicly available in the provincial fiscal plans, a Freedom of Information and Privacy (FOIP) request was also submitted at the Ministry of

Health. Data was extracted from 8 grey literature sources and legal sources in total, including the FOIP data. The results of the grey and legal searches, as well as the academic database searches, are organized into the PRISMA chart found within the methodology section. Searching the literature based on these methods enabled me to determine how effective the current model of home care is in Alberta for disabled seniors, and where gaps may lie between policy, best practice, and service delivery.

In total, the number of results analyzed from each search are in the table below:

A	13
B	3
C	4
D	4
E	14
F	11
G	1
GREY LITERATURE	8

Table 4 – Number of results from each search.

The sources analyzed in each search were then organized based on the 4 key themes. Every source was sorted into at least 1 theme, and 51 sources were sorted into an additional theme.

THEME	NUMBER OF RELEVANT SOURCES
BEST PRACTICE	29
COMMUNITY INCLUSION OF DISABLED SENIORS	24
AGING IS DYNAMIC AND SOCIAL	23
QUALITY OF CARE RECEIVED	34

Table 5 – Number of sources relevant to each theme.

Analysis

Literature

Best Practice in Home Care

Best practice is defined as the academic understanding of what care recipients require in order to achieve positive outcomes. “Positive outcomes” are highly individualized, which the literature recognizes as a key feature in the provision of care. While it is recognized that care must be individualized for each care recipient in order to be effective, there are several broader features of home care that when combined are able to inform a dynamic, adaptable system of care provision. One of these features is a person-centred approach to care, understanding that the care recipient’s family and broader social network are valuable to the care recipient (Rodrigues et al. 2019).

There are two types of practices that can be employed by individual care providers and institutions of care: hard, and soft (Hoff 2013). “Hard” practices are defined as measurable actions that can be taken by care providers, and can be assessed by measurement tools or external professional accreditation bodies (Hoff 2013). “Soft” practices meanwhile are more nuanced social approaches to the care relationship, and are more difficult to measure than task-oriented hard practices (Hoff 2013). Recipients of home care have frequently identified concerns with continuity of the care

they receive and staff retention (Thomas et al. 2007). This indicates that there is a significant gap in what is identified as best hard and soft practice, and in the experiences of home care recipients.

A critical missing piece in determining what constitutes “best practice” is the lack of standardized measurement tools across different home care organizations. A new benchmark was proposed in Europe to assess the quality of care provided to seniors and the cost of providing this care (van der Roest et al. 2019). This study gathered extensive data on home care organizations, staff, care recipients, funding, and the needs of the seniors receiving care (van der Roest et al. 2019). European home care models also provide a case study for Canadian home care delivery, as they all operate under a similar funding model but deliver the care differently from nation to nation. In a European study of home care delivery, patient-centred care was defined as best practice (Van Eenoo et al. 2018).

Community Inclusion of Disabled Seniors

As the population of Alberta ages, there has been a growing emphasis on remaining in one’s own home to age and on remaining an active member of the community. Community membership is different for every individual based on their experiences and desires, which again emphasizes the need for a customizable approach to care. Each of the sources discussed different approaches that can be taken in elder care, and all had a common theme of client-centred or person-centred care. A key feature of client-centred care is allowing the client to have as much autonomy as is safe. If care providers are given an appropriate amount of time and resources with which to spend on their clients, the autonomy of the client can be preserved (Chapman, Keating, and Eales 2003). However, the systems that administer elder home care are often unable to dedicate the resources to ensuring that staff are able to spend time with clients. Many seniors spend an inordinate amount of their daily time waiting for care providers to arrive, and such systemic shortfalls prioritize the care provider over the care recipient (Palmqvist 2022).

Autonomy is another key item that all sources in this major theme had in common. As aging in place is emphasized, one of the reasons that comes up time and again for aging in place is keeping one’s autonomy despite their changing physical support needs (Narushima and Kawabata 2020). Autonomy not only relates to having more choice over who is providing personal care (Thomas et al. 2007), but also to choosing what one does with their time. The ability to retain connections with one’s social circle was cited as one of the most important reasons to pursue aging in place (Narushima and Kawabata 2020). Social wellness is an aspect of care that continues to be deprioritized in the care system at large, and remaining engaged in the community can help prevent emotional deterioration (Daly 2007).

Another challenge that seniors in need of home care face is a decentralized system. Over the past few decades, the systemic trend has been to relinquish community responsibility of senior care and instead shift this responsibility to individuals (Hande, Jamal, and Kelly 2020). Informal care – care work provided by family members of the senior, without financial compensation – is increasingly relied upon as more budget cuts are made in the social safety net (Ceci and Purkis 2011). As budget cuts are delivered to critical home care services, physical health is prioritized over mental health and overall quality of life (Ceci and Purkis 2011). Allowing seniors to age in place and express some autonomy and control over their daily life can prevent emotional deterioration, including depression (Fjordside and Morville 2016).

One way in which aging in place can be supported is by self-management of care, sometimes also referred to as direct funding or care vouchers. Currently, informal care providers do a great deal of work for no financial compensation and it is often assumed that this work will be provided at a certain minimum standard (Grootegoed, Van Barneveld, and Duyvendak 2015). However, this assumption is not always accurate, and can impress state norms of family dynamics on people that would otherwise act differently if they received adequate support in the form of formal care (Grootegoed, Van Barneveld, and Duyvendak 2015). Informal care often provides good outcomes for the care recipient, and client-centred care is often done well by informal providers (Kietzman, Benjamin, and Matthias 2013). In the absence of adequate informal care, whether due to the client’s support needs or the informal caregiver’s personal constraints, many people would prefer to be in charge of their own formal care to whichever extent possible (Hande, Jamal, and Kelly 2020). When the state provides funding for people to direct towards home care, there is greater uptake of home care services and a tangible increase in health per $100 spent on home care by the state (Stabile, Laporte, and Coyte 2006). Client satisfaction is also higher when they are given more autonomy over their care decisions even if the budget allotted for their care is the same as when they would have not been involved in their care decisions (Carlson et al. 2007). Managing one’s own care comes at a high cost – it is time-consuming, difficult, and often very confusing. There is a program in Alberta for disabled adults to manage their own care, with

the caveat that you have to register yourself as a small business and complete all the associated taxes and administrative duties (Alberta Health Services 2014).

Aging is Dynamic and Social

It is important to first define what is meant by a social understanding of aging. Aging is both a bodily process and a social process, and it is critical to understand the interplay of these two factors. The social role of a person changes as they age and their abilities change, which many older people find frustrating (Fjordside and Morville 2016). Many seniors are accustomed to a certain amount of autonomy in their day to day lives, including decisions on their diet, exercise, lived environment, and daily schedules. When these parts of their daily lives are disrupted by increasing medical needs, many seniors feel as though they do not have control over their own lives (Fjordside and Morville 2016). One way in which the autonomy and sense of control can be upheld in the lives of seniors is through the caring relationship, which is inherently a social process (Cranford 2020). Flexible, dynamic care provision is required in order to foster trusting relationships between care providers and care recipients (Cranford 2020).

Flexible care can make some care providers wary, as they rely on defined roles of their work in order to feel as though they have job security (Cranford 2020). Home care cannot, therefore, be either wholly rigid or wholly flexible in its delivery. Responsive, socially-conscious, holistic home care must then be the dominant model in an effective system of care provision. Restrictions of public funding for home care can have a detrimental effect on the care that seniors receive, as medical care is prioritized over holistic, socially-oriented care (Daly 2007). In a system where there is a limited amount of resources available to allocate to home care, such trade-offs are made frequently (Livadiotakis, Gutman, and Hollander 2003). In extreme circumstances, seniors who are seen as having less demanding support needs may be discharged from publicly funded home care, which leaves them stranded if they are unable to afford private care (Livadiotakis, Gutman, and Hollander 2003).

Specific measures have been created in order to identify the efficacy of home care in the social domain. One paper authored in Australia identified five key domains that are essential in providing socially responsive home care: knowledge held by care providers, respect for the client and their dignity, a person-centred approach, collaboration, and clear communication (Smith, Martin-Khan, and Travers 2022). One toolkit for measuring these and other domains is the Adult Social Care Outcomes Toolkit four response-level interview schedule (ASCOT INT4) developed in England and tested in countries including the Netherlands, Germany, Austria, and Finland (Nguyen et al. 2021). The ASCOT measurement tool is able to accurately quantify a care recipient's quality of life, which includes social domains of wellbeing such as role strain and isolation (Nguyen et al. 2021).

Quality of Care Received

Hard and soft best practices are not the only factors that impact how care recipients perceive the quality of care they receive. Broader institutional practices inform what individual care providers are able to do, which in turn impacts recipients of home care. There is currently no governing body in Alberta that oversees the quality of home care provided to seniors, which creates challenges in potentially reporting any poor quality care received (Alberta 2003). Care recipients depend so fundamentally on those who provide care for them that they are often unable to choose their provider or effectively resolve any problems that may come up (Eika 2009). If a senior chooses to manage their own care instead of hiring an agency or using the care provided to them by the state, there are concerns about monitoring the quality of care provided (Carlson et al. 2007).

Informal care is heavily relied upon by both the state and disabled seniors. Formal and informal care providers work together in most cases, but there is little definition of roles (Sunde, Vatne, and Ytrehus 2022). Effective collaboration is critical to providing quality care for the client, and without proper definition of the roles of formal and informal caregivers there are substantial barriers to appropriate collaboration (Sunde, Vatne, and Ytrehus 2022). Additionally, seniors who rely on formal care report hesitation in "burdening" their family members with their care needs (Barken 2017). However, in the absence of adequate formal care, family members are often forced to fill in the gaps left behind by formal systems of care (Barken 2017). Case managers of formal care make inconsistent formal care decisions based on availability and perceived quality of the informal care (Peckham, Williams, and Neysmith 2014). The inconsistency in case management decisions speaks to a lack of quality-based regulation in home care, and in Alberta aside from home care services being vaguely described in law, there is no mechanism to oversee the quality of home care (Alberta 2003).

Policy

Based on analysis of the literature and the current policy landscape in Alberta, 3 policy options were identified to improve access to quality home care for disabled seniors: maintaining the status quo, increasing regulatory oversight of home care, and reducing the barriers to self-managed care. These options are analyzed using the framework outlined in the methodology. Options beyond the status quo will only be broad suggestions due to data and time constraints.

Status Quo

There is no indication of how the increasing home care budget is being allocated beyond broad categories of funding usage. The majority of the new funding from the 2022-2023 fiscal year is being used to invest in the "Continuing Care Transformation & Home Care Growth" strategy (Alberta Health Services 2023). The goal of this strategy is to increase the capacity of the care workforce, increase choices available to Albertans receiving home care, and increase the amount of care delivered in the community. Operational and administrative costs were not specified in either the 2023-2024 budget or the FOIP request.

The current home care policy landscape in Alberta scores low on efficacy, as there are a great deal of needs that are going unmet. It also scores low on equity, as there is insufficient specificity in the policy to support the unique, complex, and dynamic needs of seniors. The status quo also scores low on unintended effects, as hospital care currently comprises roughly 46% of total provincial health spending partially due to the aging population and a lack of effective home-delivered care (Alberta 2013). While the status quo may seem cost-prohibitive, the $902.8 million earmarked for home care only accounts for 3.7% of the current health budget, and hospitals will cost roughly $11,285.18 million based on current spending projections (Alberta 2023). It therefore ranks moderately in the domain of cost. The status quo ranks high on both feasibility and acceptability, as it is the current model of home care service delivery.

Increased Regulatory Oversight

While it is important that many different health care professionals are currently able to provide home care services, it is not clear which of these professionals are providing what proportion of the care for seniors. Additionally, there is no overarching regulatory body for formal home care services provided in Alberta. One of the major concerns of increased flexibility in home care service delivery is the lack of quality control, and increasing regulatory oversight may ensure that high-quality care is consistently provided (Eika 2009). However, regulation would increase administrative barriers and likely slow down the process of care provision, which may decrease the number of people who are able to receive home care. One of the largest barriers to effective home-care provision is administrative procedures so it will be crucial to prioritize administrative efficiency if this option is pursued (Funk et al. 2022). Another major concern in the literature with increased regulation in home care is a lack of flexibility in care provision (Funk et al. 2022). Care providers must be given the autonomy to use their best professional judgement if increased regulation is pursued.

This option is only moderate in its efficacy, as it will likely not increase the capacity of the home care system to take on more clients, but it will ensure high-quality care for seniors who are already receiving care. It is also moderate in unintended effects. There is potential for systemic biases to be further engrained with more regulation, but care provided is more likely to be higher quality for the majority of seniors receiving care. Equity is also moderate with this policy, as the seniors in care may receive higher quality care but increased administrative burden may reduce the system's capacity for taking on new clients. The cost of this option will also be moderate. There will be an increase in administrative burden due to increased oversight, but more effective care is likely to reduce the costs of hospital care in the future (Alberta 2013). Creating the regulatory bodies will also involve substantial up-front costs. This policy is strong in the domain of feasibility, as there is a great deal of precedence for regulatory oversight from other professional associations in the Health Professions Act, SA 1999, c H-5.5. The policy is weak in acceptability, as the current provincial government does not favour increased regulatory oversight and home care providers will likely worry that increased regulation will impede their ability to give quality, flexible care (Funk et al. 2022).

Reduced Barriers to Self-Managed Care

The barriers of pursuing self-managed care may be too high for the majority of seniors, which impedes autonomy. Reducing the barriers to self-managed care would allow more seniors to age in place and recognize the autonomy of seniors in their own homes. This would not drastically increase the cost needs of home care, but would instead

allocate funds so that any care provided is more effective. Increased efficacy of care could reduce the burden on other public health systems, and could even result in potential budget reallocation possibilities in the future based on reduced hospital and residential care spending (Alberta 2013). In addition to more efficient use of current funding, increased rates of self-managed care could increase seniors' autonomy in what types of care they receive. One of the key components of a critical gerontological approach is that aging is a social process, meaning that aging is socially defined, and enabling seniors to retain comparatively more autonomy will maintain their capacity for decision-making (Chong and Gu 2020). Increased autonomy in care could also enable seniors to seek out more culturally-aligned care for themselves, as care providers are currently constrained by the institution they are aligned with in terms of how they administer the care within the scope of their profession (Smith, Martin-Khan, and Travers 2022).

This option ranks high on effectiveness, as it will address current shortfalls in the system without compromising the current system altogether. Unintended effects of this policy are moderate, as it is difficult to analyze all of the downstream impacts of reducing barriers to self-managed care. It is possible that some people will use self-managed care to receive benefits they are not eligible for, but increasing autonomy to the majority of seniors receiving home care will be a greater benefit than the public funds potentially lost to a handful of bad-faith actors. This policy ranks high for equity, as increased autonomy in care provision allows seniors to receive more culturally-competent care, and more holistic care. It will not be more expensive to allow more seniors to pursue self-managed care, as these seniors would have been receiving public funds for home care regardless of how this care is administered. The only substantial costs would be increased administrative burden in the realm of self-managed care, but this burden can be redistributed from comparative lightening of management caseloads. There may be some unanticipated costs due to reduced barriers for this program, and for these reasons it ranks moderately for cost. This policy is also strong in the domain of feasibility, as it will not be overtly challenging to reduce the barriers of self-managed care. A suggestion to ease the challenges of this policy change would be to reallocate administrative support from publicly-managed home care, perhaps to a program that oversees self-managed care. This policy is also strong in acceptability. The current provincial government is in favour of reduced government involvement in public services (Alberta 2023), and the majority of seniors in Alberta are in favour of both aging in place and exercising autonomy in their own care.

Recommendation

Based on the analysis it is recommended that the Government of Alberta pursue the third option, lowering barriers to self-managed care for disabled seniors. The analysis rubric (depicted in the methodology section) was used to score each of the options on a scale from 1 to 3 in each domain. Once scoring was completed, all options and their scores were plotted on a radar chart. The option that took up the largest surface area on the chart is the option that best aligns with the described criteria.

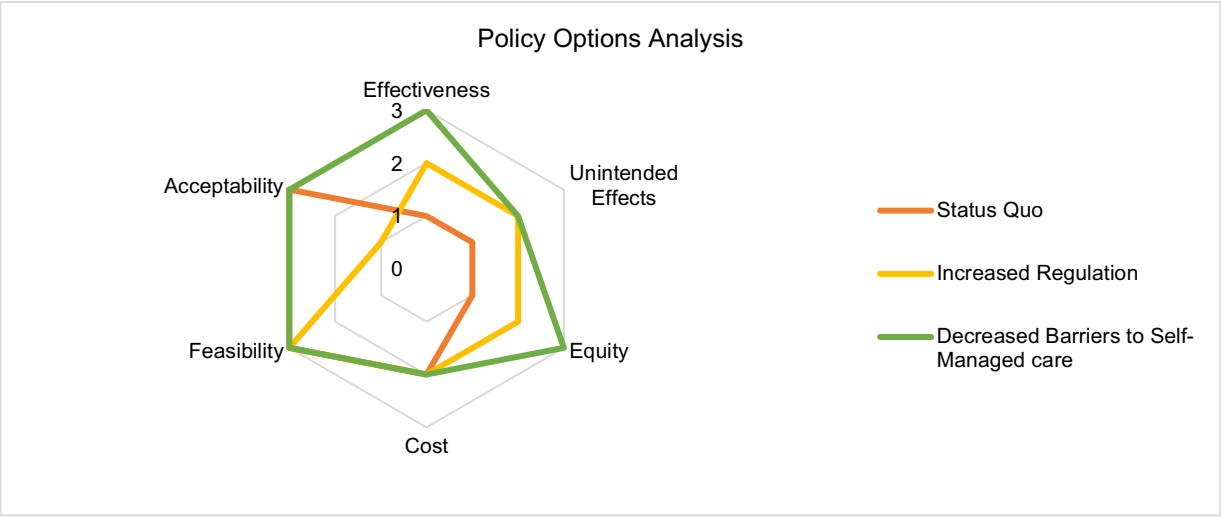

Figure 2 – Analytic radar chart generated by the author.

Discussion

Literature

There was ultimately very little literature available on the provision of home care for disabled seniors specifically. The majority of the literature focused on the experiences of the care provider rather than the care recipient, which demonstrates a devaluing of the lived experiences of care recipients. The current policy and legal landscape of home care in Alberta is complex. There is very little information on the topic that is publicly available, and even after submitting a FOIP request much of the analysis relied on broader academic literature. Future research must centre the voices of care recipients, and must take regional policy differences into account.

Policy

Summary of Proposed Options and Analysis

DECISION CRITERIA	STATUS QUO	INCREASED REGULATION	REDUCING BARRIERS TO SELF-MANAGED CARE
EFFECTIVENESS	1/3 – high proportion of unmet care needs	2/3 – likely won't increase system capacity, will ensure quality	3/3 – address shortfalls without compromising current system's positives
UNINTENDED EFFECTS	1/3 – a lack of quality home care contributes to high hospital costs	2/3 – potential for systemic biases to be further ingrained, could lead to more culturally sensitive care due to oversight	2/3 – difficult to ascertain all unintended effects, increased autonomy may lead to decreased quality of care for some
EQUITY	1/3 – current care does not take into account the diversity of Albertans	2/3 – increased administrative burden may impede access for new clients	3/3 – more autonomy in type of care and amount of care
COST	2/3 – potentially inefficient spending but only 3.7% of total health budget	2/3 – increased administrative costs, likely decrease in hospital costs	2/3 – some administrative burden for program guidance, costs could be redistributed from decreased management load
FEASIBILITY	3/3 – very easy to maintain current system.	3/3 – precedence from other regulated health professions	3/3 – not time-consuming or complex to initiate
ACCEPTABILITY	3/3 – very easy to maintain current system.	1/3 – increased regulation may reduce flexibility in care	3/3 – reduces government involvement, aligns with seniors' desire to age in place

Table 6 – Summary of how options were ranked based on evaluative criteria.

Recommendation

Based on the available policy information and the analysis conducted above, it is recommended that the Government of Alberta pursue reducing barriers to self-managed care for disabled seniors. Self-managed care is aligned with a critical gerontological approach to aging in place, and would fulfill state obligations to care for disabled seniors without disproportionately burdening the state or seniors who require care. Currently in order to pursue self-managed care, one must register themselves as a small business and file appropriate taxes for each worker that provides care for them (Alberta Health Services 2014). By enabling seniors who are receiving care to assert autonomy over their care decisions, the same amount of funding can be maintained and will be directed more effectively. One way in which this can be achieved is by reducing the administrative burden on individuals receiving care, and creating an oversight program for self-managed care clients. Clients would be able to choose what type of care they receive, choose how many hours of care they receive, and have more autonomy over the individual workers in their homes, all without being required to file business taxes and keep track of payroll taxes for the individual care workers. These financial and administrative responsibilities would remain with the system. This option would also provide the greatest amount of quality control in self-managed care. Due to care workers being paid by the public health system, the lack of

current regulatory oversight into home care would be mitigated by administrative processes in the hiring and reporting processes taken on by the state.

Monitoring and Implementation

A critical part of the policy process is monitoring the implementation of a policy. Key statistics can be used to study the uptake of self-managed care, for example the number of people beginning self-managed care or the number of workers who report providing care for somebody who manages their own care. Another quantitative measure could include the money spent on home care year over year or month over month. For a more in-depth study of self-managed care, care recipients and their support networks could consent to interviews or responding to surveys. A pilot project could be a favourable way to gauge the interest in self-managed care, perhaps by opening reduced barriers self-managed care to a demographically representative population of Albertans so that the success of the policy can be measured and studied based on whether or not it achieves its purpose in a smaller group.

A logic model is one way to visualize the way in which a policy is intended to address the policy problem. It also outlines some of the key stages within the implementation process. A logic model has been enclosed below to demonstrate how reducing barriers to self-managed care will ultimately increase the quantity and efficacy of home care in Alberta. By reducing barriers to self-managed care, it is likely that more people will use self-managed care. This will increase the autonomy of care recipients, which improves the care outcomes for seniors. People are unlikely to request care services that are unnecessary, which will free up resources for those who need them. Funding will therefore be used more efficiently, which will then increase the overall capacity of the home care system.

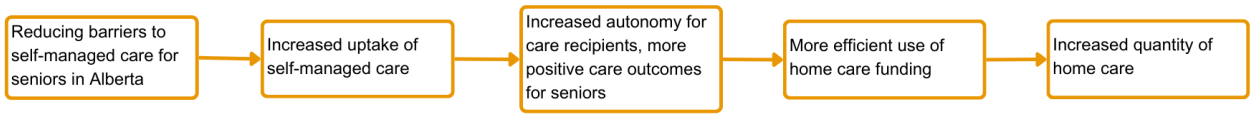

Figure 3 – Logic model created by the author.

Limitations

This capstone is limited by a lack of publicly available data on Alberta's home care policies and system. More detailed information would enhance the analysis by allowing for more informed policy recommendations to be created. Additionally, time constraints limited the author to the study of only Albertan law and policy. A cross-jurisdictional analysis would also have enhanced the recommendations provided. Time constraints also limited the approach to a Cochrane-style literature review. Conducting a more in-depth analysis by interviewing experts on Albertan home care law and policy would have created a more thorough analysis of the current policy landscape. It is also critical to recognize unconscious biases held by the researcher as a limitation. Future study in this area ought to include a more diverse research team to ensure that the presence of implicit bias is limited. Indigenous perspectives must be centred more, as they were neither prioritized nor referenced in the research found during data collection for this analysis.

Conclusion

The population in Alberta is aging more rapidly than our current social safety net is able to support. While there are many options available for senior care, the overwhelming majority of Albertans want to receive care in their own homes and to make their own decisions. A lack of institutional oversight may provide some seniors with autonomy, but others are being left behind in the quest for systemic deregulation. Increasing access to guided, self-managed home care for seniors in Alberta would be the most effective use of home care budgetary provisions and would be the most feasible compromise between institutional desires and individual needs. To make informed decisions about home care for seniors in Alberta, policymakers and researchers need more transparent information about budget allocation and service provision.

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